Commonwealth of Massachusetts
Group Insurance Commission

P.O. Box 8747 • BOSTON, MA 02114-8747
(617) 727-2310 www.mass.gov/gic

Municipality Insurance Enrollment and Change Form (FORM -1MUN)

01 ☐

Insured's GIC-ID (usually Soc. Sec. #)	Sex: Male ☐ Female ☐	Date of Birth	Dept. ID # or Agency/Division #
___ ___		/ /	/

Name - Last | First | MI

Address	☐ This is a new address	City	State	Zip Code

Date Entered Service	Bargaining Unit/Union Name	HR/CMS or UMASS Employee ID #:	Home Phone	Work Phone
/ /			( )	( )

02 ☐ **HEALTH COVERAGE** **Effective Date: / 01 /**

New Enrollment ☐ | Change ☐ | **Cancel Coverage** ☐

☐ **Health** (Select one of the health plans below and individual or family coverage)

Health Plan

☐ **Commonwealth Indemnity Plan Basic** CIC: ☐Yes ☐ No Coverage

☐ **Commonwealth Indemnity Plan Community Choice** ☐ **Harvard Pilgrim Independence Plan** ☐ **Navigator by Tufts Health Plan** ☐ **Individual**

☐ **Commonwealth Indemnity Plan PLUS** ☐ **HMO:** _____ ☐ **Family**

(write in the name of the HMO)

03 ☐ **Name Change**	Previous Name	New Name

INSURED CHANGES **FOR GIC USE ONLY:** **Effective Date: / 01 /**

06 ☐ **Retirement** Date Retired / /

07 ☐ **Transfer to another Agency** Name of Agency Transferred to Effective Date / /

08 ☐ **Transfer from another Agency** Previous Agency Effective Date / /

09 ☐ **Termination Coverage (if elected)** Termination Reason _____ Termination Date ____ /____ /____

☐ 39 -Week Layoff Coverage ☐ Deferred Retiree ☐ COBRA (must complete COBRA application) ☐ Conversion (contact carrier for application)

SIGNATURE REQUIRED

Deduction Authorization

I authorize my employer, or direct my pension authority , to deduct from my payroll or pension check the amount required for the coverage I have selected.

At Retirement

I hereby certify that I have filed, or intend to file, an application for retirement and desire to continue my present coverage as a retiree. I also understand that if I am Medicare eligible, I am required to join one of the Group Insurance Commission's Medicare supplemental health plans to continue health coverage.

Termination

I understand that by electing to continue coverage under COBRA or Conversion, I must complete and return the corresponding application in order for this coverage to go into effect.

• If you are applying for Health Insurance, be sure to file a Form IDF to list family members • If you are enrolling in an HMO, be sure to file an application with the Plan.

x _____ Signature of Applicant Date

x _____ Signature of Authorized Official Date

FOR GIC USE ONLY:	Entered	Verified	Political Subdivision